MCA Administrators, Inc.

Request for Predetermination

Fax completed form to: 412-202-5763 Note: Note: To avoid delay in processing your request, please fill out this form completely. Photo copies and all Medical Records must be faxed to 412-202-5763.

_____

Physician or Provider Name _____

Physician or Provider Tax ID _____

Address _____

Contact Person Telephone_____ **Email Address**_____

Name of Facility _____

Facility Address _____

Anticipated Date of Service ___ / ___ / _____ □ Outpatient □ Inpatient □ Observation Admission

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Subscriber Name _____

Subscriber Number _____

Patient Name _____

Patient Date of Birth ___ / ___ / _____ Group/Policy Number _____

_____

SERVICE DESCRIPTION

Diagnosis Codes	**CPT**	**HCPCS**
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

Comments/Notes Describing the Service: _____

Is this a continuation of previous Approval: Yes _____ No _____

Note: If the initial Pred is not Approved. Please fax any new documentation with this form for review. Examples include: • Test Results (lab, visual fields, radiology, sleep study, etc.) • Patient's Current Condition • Pertinent History/Evaluation • Progress Notes-